General

Guideline Title

Fall management guideline.

Bibliographic Source(s)

Health Care Association of New Jersey (HCANJ). Fall management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2012. 34 p. [41 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Health Care Association of New Jersey (HCANJ). Fall management guideline. Hamilton (NJ): Health Care Association of New Jersey (HCANJ); 2007 Mar. 32 p.

Recommendations

Major Recommendations

Program Outline

Each health care system is encouraged to use this comprehensive guideline to outline and further define its' program specific, fall management policy and procedures.

Key Elements to a Fall Management Program

A. Facility leadership approval and participation
B. Assessments
C. Dynamic treatment plan
    1. Role of Interdisciplinary Team or Resident Review Team
    2. Use of non-pharmaceutical interventions
D. Appropriate and necessary use of devices (enablers, restraints)
E. Re-assessments, implementation and evaluation of treatment plan
F. Education/awareness

Detailed Elements

A. Assessment

1. Clinical assessment
    a. Assessment form - recommend rating scale
    b. Completed by registered nurse
        1. Time of completion
        2. Admission fall risk assessment completed within 24 to 48 hours of admission
        3. If indicated, comprehensive fall risk assessment within 14 to 21 days after admission
    c. Frequency of reassessment
        1. Upon a fall
        2. Significant change likely to increase fall prediction factor
        3. Quarterly for skilled nursing facilities and nursing facilities
        4. Semi-annually for assisted living facilities
2. Rehabilitation assessment
    a. Completed by physical therapist (PT) or occupational therapist (OT)
    b. Form: (e.g., Tinetti Gait and Balance Tool or Berg Balance Scale)
    c. Transfer evaluation
    d. Evaluate for vestibular imbalance
    e. Time of completion (recommend 24 to 48 hours after referral)
    f. Frequency of re-evaluation (see assessments)
3. Continence protocol as indicated
    a. Toilet schedule
    b. Bladder training, as indicated
4. Mental status assessment
    a. Complete mini-mental status assessment
    b. Recall
    c. Judgment (safety awareness)
5. Pain assessment
    a. Opioid use
    b. Chronic unrelieved pain
    c. Acute exacerbation of usually controlled pain
    d. New pain
6. Review record of diagnoses which contribute to increased falls risk, such as
    a. Orthostatic hypotension
    b. Osteopenia
    c. Osteoporosis
    d. History of falls
    e. Dementia
    f. Delirium
    g. Sensory impairment (hearing, touch, sight)
    h. Parkinson's
    i. Atrial fibrillation
    j. Seizure disorders
    k. Arthritis
    l. Vertigo
    m. Cerebrovascular accident (CVA)
    n. Loss of limb(s)
    o. Fractures
    p. Anemia
    q. Wandering
    r. Anger
7. Pharmacological assessment and review
    a. Completed by pharmacy consultant or physician
    b. Review of medication profile
    c. New or changed medications
    d. Use of off label antipsychotics

e. Use of benzodiazepines
f. Inappropriate medications for the elderly Review Beers Criteria
g. Adverse or idiosyncratic medication reactions or interactions

8. Environment assessment
    a. Physical room layout
    b. Equipment and assistive devices
    c. Lighting
    d. Other
9. Analysis/assess level of risk assessment
    a. Identify level of risk based on collective assessments and professional judgment

B. Dynamic Treatment Plan
1. Specific interventions based on results of fall assessment and client preferences. The interdisciplinary/resident team members must address:
    a. Resident, staff, and family teaching
    b. Room modifications
    c. Resident's daily routines
    d. Mental status/behaviors
    e. Physical limitations
        1. Activities of daily living (ADL) skills
        2. Continence
    f. Pain
    g. Medication use
    h. Non-pharmaceutical interventions in place
    i. Consistent appropriate and proper uses of assistive or protective devices, electronic scooters, etc., based on assessments
2. Updated information communicated to the staff, resident and family
    a. Staff
        1. General classification system identifying resident's potential to fall
        2. Summary of assessments/changes in services or care plan
        3. Verbal and written reports
    b. Residents: One-to-one education and review
    c. Families: Care/status review conferences, attendance/participation

C. Evaluation
1. Post fall evaluation
    a. Fall Management Investigation or Post Fall Assessment Tool
        1. Physical assessment
        2. Contributing factors to fall
        3. Medication changes (new or discontinued)
        4. Mental status changes
        5. New diagnoses
2. Reporting mechanism/tracking of falls within the facility
    a. A facility "Facility Fall Summary/Analysis"
    b. Action of the interdisciplinary team
        1. Timely modifications to the treatment plan
        2. Family/resident conferences
        3. Physical adaptation to room, wheelchair, and/or walking devices
    c. Collective review, identification, and analysis of trends in resident falls throughout the facility (see "Quality Improvement," below)
3. Facility protocol may include falls management review and analysis by the safety committee, falls committee, interdisciplinary care (IDC) plan committee, quality improvement committee, or other established interdisciplinary group

D. Education/Awareness
1. Falls Program In-service
    a. Staff members

1. Intervals for review of Fall Management Program:
    a. Upon orientation
    b. Semiannual
    c. Post fall evaluation as necessary
2. Contents of review
    a. Policies and procedures
    b. Documentation standards

b. Resident
1. Intervals for review of fall/safety information:
    a. Admission
    b. Care plan meetings
    c. Quarterly resident population education on falls management
    d. After a fall
2. Contents of review:
    a. Instructions and information concerning safety awareness
    b. Proper use of call bells, walking devices, wheelchairs, and other assistive devices

c. Family
1. Intervals for review of fall/safety information:
    a. Upon admission of the resident
    b. Address with family as resident presents need to discuss
    c. Upon discharge of resident
2. Contents of review:
    a. Reasonable expectations from the facility
    b. How they can assist

d. Department of Health and Senior Services (DHSS)
1. Inform the department of health personnel about the facility's Fall Program and what is the level of implementation

E. Quality improvement
1. Collect falls data (including near miss data)
    a. Post fall tool
    b. Falls summary report
        1. Conduct interdisciplinary analysis of information to gain helpful knowledge
        2. Review and revise policies and procedures as appropriate
            a. Retrain staff on new policies and procedures
2. Complete facility falls data summary document
    a. Analyze information
    b. Revise policies and procedures as appropriate
        1. Retrain staff on new policies and procedures

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

- Falls
- Injuries from falls

Note: A *fall* is defined as an occurrence characterized by the failure to maintain an appropriate lying, sitting or standing position, resulting in an individual's abrupt, undesired relocation to the ground. The definition of a fall extends to and includes following factors:

An episode in which a resident has lost his/her balance and would have fallen were it not for staff intervention.
The presence or absence of a resultant injury; a fall without injury is a fall.
The distance to the next lower surface (in this case, the floor) does not determine the incidence of a fall. (i.e., bed or mattress close to the floor)

Guideline Category

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Family Practice

Geriatrics

Internal Medicine

Nursing

Physical Medicine and Rehabilitation

Preventive Medicine

Intended Users

Health Care Providers

Managed Care Organizations

Nurses

Occupational Therapists

Physical Therapists

Physician Assistants

Physicians

Guideline Objective(s)

- Limit and/or prevent the occurrence of falls within the parameters that can be controlled through structured program interventions
- Minimize the severity of injuries sustained by an elderly individual resulting from a fall
- Provide the professional staff with standards of practice that will enable them to perform and teach effectively
- Educate the resident, family and direct care and ancillary staff
- Limit the liability and financial risk to the facility

Target Population

Residents of long-term care facilities, including skilled nursing facilities, subacute care, and assisted living facilities

Interventions and Practices Considered

1. Assessments
    - Clinical
    - Rehabilitation
    - Continence protocol
    - Mental status
    - Pain
    - Pharmacological
    - Environmental
    - Level of risk
2. Dynamic treatment plan
    - Interdisciplinary team assessment and intervention
    - Updated information and communication
3. Evaluation
    - Use of fall management investigation or post fall assessment tool
    - Reporting mechanism/facility tracking
4. Education/awareness
    - Fall safety information and staff in-service
    - Inform Department of Health and Senior Services (DHSS) about the facility's fall program
5. Quality improvement
    - Falls data
    - Review and revise policies

Major Outcomes Considered

- Change in risk of falling
- Number of falls (with or without injury)

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

- Databases searched included Agency for Healthcare Research and Quality (AHRQ); Centers for Disease Control and Prevention (CDC); Center for Excellence in Assisted Living (CEAL)
- Multiple physical therapy websites were reviewed:
    - National Center for Patient Safety: http://www.patientsafety.gov/CogAids/FallPrevention/
    - Patient Safety & Quality Healthcare: www.psqh.com/mayjun06/falls.html
    - Institute for Healthcare Improvement: www.ihi.org
    - Wisconsin Department of Health Services - Fall Prevention: http://www.dhs.wisconsin.gov/health/InjuryPrevention/FallPrevention/
    - American Physical Therapy Association: http://www.apta.org
- Other resources reviewed:
    - Transforming Care at the Bedside (TCAB): http://www.rwjf.org/content/rwjf/en/research-publications/find-rwjf-

research/2008/06/the-transforming-care-at-the-bedside-tcab-toolkit.html
    - Yale FICSIT (Frailty and Injuries: Cooperative Studies of Intervention Techniques)
- Date range of literature searches: 2008 - 2012.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Rating Scheme for the Strength of the Evidence

Not applicable

Methods Used to Analyze the Evidence

Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

This Best Practice Guideline was developed by the Health Care Association of New Jersey (HCANJ) Best Practice Committee ("Committee"), a group of volunteer professionals actively working in or on behalf of health care facilities in New Jersey, including skilled nursing facilities, sub-acute care and assisted living providers.

The Committee's development process included a review of government regulations, literature review, expert opinions, and consensus. The Committee strove to develop guidelines that are consistent with these principles:

- Relative simplicity
- Ease of implementation
- Evidence-based criteria
- Inclusion of suggested, appropriate forms
- Application to various long term care settings
- Consistent with statutory and regulatory requirements
- Utilization of minimum data set (MDS) resident assessment instrument (RAI) terminology, definitions and data collection

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

Not stated

Description of Method of Guideline Validation

Not applicable

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of evidence supporting the recommendations is not specifically stated.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Appropriate fall management in reducing falls, minimizing injuries, and ultimately improving the quality of life of residents
- Limited liability and financial risk to the facility

Potential Harms

Not stated

Qualifying Statements

Qualifying Statements

- This Best Practice Guideline is presented as a model only by way of illustration. It has not been reviewed by counsel. Before applying a particular form to a specific use by your organization, it should be reviewed by counsel knowledgeable concerning applicable federal and state health care laws and rules and regulations. This Best Practice Guideline should not be used or relied upon in any way without consultation with and supervision by qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.
- This Best Practice Guidelines is offered to nursing facilities, assisted living communities, residential health care facilities, adult day health services providers and other professionals for informational and educational purposes only.
- The Health Care Association of New Jersey (HCANJ), its executers, administrators, successors, and members hereby disclaim any and all liability for damage of whatever kind resulting from the use, negligent or otherwise, of all Best Practice Guidelines herein.
- The Best Practice Guidelines usually assume that recovery/rehabilitation is the treatment or care plan goal. Sometimes, other goals may be appropriate. For example, for patients receiving palliative care, promotion of comfort (pain control) and dignity may take precedence over other guideline objectives. Guidelines may need modification to best address each facility, patient and family's expectations and preferences.
- The Falls Management Program is designed to assist personnel to reduce falls, minimize injury and ultimately improve the quality of life of our residents. This Best Practice Guideline should not be used or relied upon in any way without consultation with and supervision by

qualified physicians and other healthcare professionals who have full knowledge of each particular resident's case history and medical condition.

Implementation of the Guideline

Description of Implementation Strategy

Appropriate staff (Management, Medical Director, Physicians, Nurse-Managers, Pharmacists, Pharmacy Consultants, Interdisciplinary Care Team) at each facility/program should develop specific policies, procedures and protocols to best assure the efficient, implementation of the Best Practice Guideline's principles.

Recognizing the importance of implementation of appropriate guidelines, the Committee plans to offer education and training. The HCANJ Best Practice Guidelines will be made available at www.hcanj.org.

Implementation Tools

Chart Documentation/Checklists/Forms

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

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Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2003 Sep (revised 2012)

Guideline Developer(s)

Health Care Association of New Jersey - Nonprofit Organization

Source(s) of Funding

Health Care Association of New Jersey

Guideline Committee

Best Practice Committee

Composition of Group That Authored the Guideline

Not stated

Financial Disclosures/Conflicts of Interest

Not stated

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Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Health Care Association of New Jersey Web site .

Print copies: Available from the Health Care Association of New Jersey, 4 AAA Drive, Suite 203, Hamilton, New Jersey 08691-1803

Availability of Companion Documents

The following implementation tools are available in the original guideline document .

- Best practice tools: assessment, plan of care and investigation forms
  - Fall risk predictive factors assessment
  - Falls management: optional initial plan of care
  - Falls management investigation—post fall tool
  - Falls management post fall assessment tool
- Tinetti assessment tools
- Berg balance measure
- Confidential quality improvement (QI) forms
  - Facility falls summary report

- Facility falls data summary
- Falls management guidelines quantitative measurement record

Print copies: Available from the Health Care Association of New Jersey, 4 AAA Drive, Suite 203, Hamilton, New Jersey 08691-1803

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on July 18, 2005. The information was verified by the guideline developer on July 20, 2005. This NGC summary was updated by ECRI on April 10, 2009. The updated information was verified by the guideline developer on September 25, 2006. This NGC summary was updated by ECRI Institute on July 6, 2009. This NGC summary was updated by ECRI Institute on March 5, 2013. The updated information was verified by the guideline developer on March 29, 2013.

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